Medical Assistance Administration

JUSTIFICATION FOR USE OF MISCELLANEOUS PARENTERAL SUPPLY PROCEDURE CODE (B9999)

Fax this form, your invoice, and prescription for review to MAA, Attention: Home Infusion/Parenteral Nutrition, FAX (360) 586-1471, **prior to submitting your claim.**

AGENCY NAME	AGENCY PROVIDER NUMBER
CLIENT NAME	CLIENT PIC NUMBER
CLIENT DIAGNOSIS	MAA REVIEW NUMBER

DATE OF SERVICE	EQUIPMENT NAME	STATUS
		☐ RENTED ☐ OWNED

MEDICAL NECESSITY	UNITS REQUESTED

DATE OF SERVICE	EQUIPMENT NAME	STATUS
		☐ RENTED ☐ OWNED

MEDICAL NECESSITY	UNITS REQUESTED

DATE OF SERVICE	EQUIPMENT NAME	STATUS
		☐ RENTED ☐ OWNED

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		☐ RENTED ☐ OWNED

MEDICAL NECESSITY	UNITS REQUESTED

FOR MAA USE ONLY

☐ Approved ☐ Denied Not Medically Necessary ☐ Alternate Code Suggested ________ ☐ Part of Global Fee For ________

DESCRIPTION

PAYMENT PER UNIT	TOTAL PAYMENT	LOGGED DATE	Need to establish code: ☐ YES ☐ NO